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Social Thinking® Speech-Language History

THIS QUESTIONNAIRE MUST BE SENT BACK TO ME BEFORE THE ASSESSMENT MEETING OR THE ASSESSMENT WILL BE RESCHEDULED.

Child's Name: ___________________________
Child's Date of Birth: __________________________
Age: ________________________
Child's Current School: _________________________
Child's Grade in School: ___________________
Parent(s) Name: _________________________
Parent(s) Occupations: ____________________
Address: ______________________________
____
Telephone: ____________________________
Cell phone: ___________________________
E-mail address: _________________________
Referred by: ___________________________

Your Specific Concerns/Reason(s):
____

____

Birth History:
Does your child have a specific diagnosis/diagnoses?

___________________________At what age? ________________
___________________________At what age? ________________
___________________________ At what age? ________________

Any difficulties at birth or right after birth? ___________________
____
History of high fevers? _____________, convulsions? ___________
accidents? _______________
surgery? _________________
frequent or chronic ear infections? __________________
sore throats? ___________, allergies (foods, etc.) ___________
Does your child regularly take medication? _________________
If so, please indicate type of medication and reason for medication:
____
Is your child on a special diet? Please specify. _____________
____

Developmental History:
Did your child babble as an infant?________________
Age of first words ____________, 2 word combinations ________
Short sentences ____________

Do you have any concerns about how your child understands language skills (i.e. following directions, answering questions)? If yes, please explain _______________________
____

Does/Did your child have a history of chewing, sucking, or swallowing difficulties? ____________________________

Age your child sat unsupported ____________, crawled __________
walk independently ___________________, completed toilet training _______________

If applicable, how much of your child's speech can you understand?
____

If applicable, can other members of your family, strangers, teachers understand your child? _______________________________

____

Is your child's speech difficulty (sounds production) interfering with his/her ability to socialize/interact/talk with others?

____

____

How is your child doing at school academically? __________________

____

____

____

How is your child doing socially in school? Does he/she have friends?

____

____

____

____

Does your child show understanding of the feelings of others?

____

Does your child show understanding of the body language and facial cues of others? ____

What are some social strengths and weaknesses of your child?

Describe some specific social difficulties experienced by your child.

What are your child's interests?

____

Overall, how would you describe your child (i.e. happy, nervous, sense of humor, etc). ____

____

How would peers describe your child? ______________________

____

____

How do you think your child would describe himself?

____

____

____

How do feel his school program is addressing/not addressing your child's areas of need?

____

____

____

____

____

____

Family History:

Names and ages of child's siblings _______________________

____

Any pets at home? If so, name and type. ___________________

Is there any history of speech/language or learning difficulties in your family? If yes, please explain. ______________________

____

What language(s) are spoken your home? _____________________

Evaluation History:

Has your child been seen for a speech/language, learning, psychological or neurological evaluation? ___________. If yes, please explain reason for and results of evaluation.

____

____

____

Is your child under the care of another professional (i.e. psychologist/ psychiatriast/counselor)? Please specify and reason why.

____

____

____

Has your child received speech therapy in the past? ___________
If yes, please indicate approximate dates of therapy, the type of therapy provided, and why therapy was/is needed.

____

____

____

Has your child received a hearing evaluation? When, where, and what were the results?

____

What are your goals for your child? ________________________

____

____

Any additional information that you consider important:

____

____

____

____

During the evaluation (and therapy sessions, if applicable), I give permission for you to audiotape/videotape for the strict purpose for writing up your child's reports and documenting progress/plans

Please circle one: Yes No ________ Initials

If you are providing other reports/evaluations/IEP's/progress reports, etc. to me and I am writing a formal evaluation for your child, <u>then you are allowing me to use and refer to those reports/evaluations in my written evaluation.</u>

________ Initials

Should your child become part of a social thinking group, there probably will be times that I will need to contact you, the parents as a group via emails. You are giving me permission to send a group email (with no personal health/diagnosis information about your child contained in these emails).

__________ Initials

Should your child become part of the groups, if you ever have any questions or concerns or not understand our post-session discussions, please call me right away.

____________ Initials

Should your child become part of a group, you approve of a parent group discussion at the end of the session-that would involve talking about what happened during the session and what your child said/did with other parents present.

_____________ Initials

Please know that all the information you have provided in this form will be kept confidential and will only be used for evaluative and therapeutic purposes.

_________________________ _______________________

Parent Signature Date

Please send this questionnaire back to me before the assessment or else the assessment will have to be rescheduled.